South Texas Gynecologic Oncology
BHS PHYSICIANS NETWORK

Authorization for Release of Medical Information

Patient Full Name_____ DOB___/___/___ SSN_____

Previous/Other Name (if different than listed above)_____

This will authorize:	**To release to:**
South Texas Gynecologic Oncology	Practice Name:_____
540 Madison Oak, Suite 570	Address:_____
San Antonio, TX 78258	City, State, Zip:_____
210-402-3700 phone	Phone:_____
210-402-3892 fax	Fax: _____

Medical Records Requested From (dates): _____ to _____

--OR--

List specific records requested (labs, imaging, progress notes, etc.)_____

(if this section is left blank, a summary of records from the last 2 years will be provided)

Reason for release:_____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION
PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to (check yes or no):

YES	NO	
___	___	Substance abuse (alcohol/drug abuse)
___	___	Mental health/depression (includes psychological testing)
___	___	HIV-related information (AIDS related testing)

This consent may be revoked at any time by notifying the above named provider of information in writing. This release will expire 1 year after date on this form, unless another date is specified here: _____, in which case release will expire on specified date. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosed information may be reviewed by contacting the provider of information.

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations. I understand I do not have to sign this authorization in order to obtain health care services.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. This facility has contracted with HealthPort to make copies. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.

_____
Signature of patient or authorized representative
Date ___/___/___